Montana Medicaid Claim Jumper

New Billing Requirements for Outpatient Hospitals, RHC, FQHC, and IHS beginning April 1, 2003

UB-92 claims submitted on or after April 1, 2003 (regardless of date of service) will require all line items to have a valid date of service (UB field 45). In addition, IHS, FQHC and RHC claims will now require a valid CPT or HCPCS code (UB field 44). These changes are being made for three reasons.

First, as a requirement of a legislative audit, DPHHS has been required to change MMIS to automatically review the billing of individual lab codes that are part of a lab panel to determine if the codes should be reimbursed as a panel or as an individual lab code and to prevent duplicate billing.

Second, hospital outpatient reimbursement methodology will be changed from a DPG methodology to an APC methodology in July 2003.

Third, these changes are requirements of HIPAA. ACS anticipates being able to accept HIPAA compliant claims in July 2003.

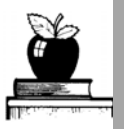
For further information about these new billing requirements and for a list of revenue codes that will require a separate line for each date of service, please refer to the Provider Information website. The notice in its entirety is available under *Notices and Replacements Pages*.

Publications Reminder

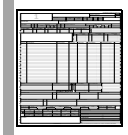
It is the providers' responsibility to be familiar with the Medicaid manuals, fee schedules, and notices for their provider type, as well as other information published in the *Claim Jumper* and on the website.

Billing With CDT-4 Dental Codes

Effective February 1, 2003, CDT-4 dental codes will replace the existing CDT-3 dental codes. The ACS Claims Processing Unit will accept the new CDT-4 procedure codes in February. Providers can continue to bill the CDT-3 codes through June 2003. Any services provided July 1, 2003 and after must be billed using the CDT-4 procedure codes. A new Medicaid fee schedule will be available soon on the Provider Information website.





Podiatry Update

In the Montana Medicaid notice, dated January 10th 2003, Podiatry services were proposed to be eliminated as optional services for individuals age 21 and over. Podiatry *will* continue to be a covered service. Podiatry services will still see a net payment reduction of 7% on provider reimbursement.

Are You Receiving Multiple Mailings?

A Claim Jumper is mailed to each provider who has an active Montana Medicaid provider number. Therefore, if a provider has several active Medicaid numbers, the provider will receive a Claim Jumper for each provider number. If your facility would like to eliminate receiving multiple mailings of the Claim Jumper, you may be able to terminate excess provider numbers.

Providers practicing at several locations, but who operate under one tax identification number, may use one Medicaid number for all locations. Providers included in this policy are physicians, mid-level practitioners, podiatrists, optometrists, audiologists, hearing aide providers, durable medical equipment providers, ambulatory surgical centers, dentists, free standing dialysis clinics, physical, occupational and speech therapists, pharmacists, EPSDT providers, private nursing providers, personal assistance providers, home and community based services providers, nutritionists and QMB chiropractors.

Remember that providers must have a Medicaid number assigned to each tax identification number and must have a Medicaid number for each provider type.

Providers who choose to use one Medicaid number can designate which Medicaid number to keep. Letters of termination for the provider numbers must be sent to Provider Relations.

TPL TIPS

Claims often deny for several TPL reasons. Each month we try and provide tips to help providers avoid billing problems with TPL.

- Providers should not indicate cost sharing amounts as TPL payments. If the client has not satisfied their cost sharing amounts it will be deducted twice, once as a TPL amount and the other as cost sharing.
- If you need to resubmit a claim, do not list prior Medicaid payments. The prior Medicaid payment will be picked up as TPL and may cause your claim to pay inappropriately. Paid claims that require corrections should not be resubmitted; they should be adjusted.
- If the primary insurance company denies claims for a Medicaid client, please remember to send the insurance denial along with the explanation of the reason codes to Claims Processing. If the explanation of reason codes is not attached, Medicaid cannot process the other insurance's denial and your claim will be denied.

Only send problem TPL claims directly to the TPL unit. TPL claims that require no special attention should be sent directly to claims processing.

Hysterectomy Form Clarification

There are three sections of the hysterectomy consent form and each is independent of the others. The following provides guidelines on how to appropriately use the hysterectomy form.

Section one of the form is to be used when clients are having a planned hysterectomy. The client is required to fill out the hysterectomy form 30 days in advance of the procedure, per 42 CFR 441.258. The physician must also sign and date the form.

Section two of the form is completed by the physician if a client is already sterile. The physician must give the reason the client is sterile and sign and date this portion of the consent form. The client is not required to sign the form when they are already sterile and the provider has determined a hysterectomy is needed.

Section three of the hysterectomy form is to be used when a life threatening emergency requires a hysterectomy. The physician is required to define the emergency and sign and date the form. If you have further questions about how to use the hysterectomy form, please contact Provider Relations.

Modifier Reminder

When billing with modifiers on a CMS-1500, please be sure to put pricing modifiers in the first or second slot of field 24d so that the claim will price correctly.

Frequently Asked Questions

Q: What is the time frame for claims to process through the Medicaid system and get paid?

A: For those providers who are not receiving weekly payment, electronic claims usually take one to two weeks. However, if the claim suspends on the night of payment cycle, it can take three weeks to pay. Paper claims will ordinarily take between four to six weeks. Claims are often suspended in the Medicaid system to be reviewed, either by ACS or Department staff. These claims are reviewed as soon as possible and sent back through the Medicaid system for either payment or denial.

Q: How long do we need to keep documentation of Medicaid claims?

A: According to ARM 37.85.414, Medicaid claim documentation must be kept for six years three months.

Q: What's the cure for a suspect duplicate denial where another provider is paid for the same service?

A: When it is truly a duplicate because another provider has already been paid, you will need to appeal the claim to the Department. If it is a modifier problem, you could contact the other provider and ask them to adjust their claim with an appropriate modifier so that you can both get paid.

ACE$ Tips

When billing electronically using ACE$, claims submitted on a holiday are batched for processing the following business day. ACS holidays are New Years Day, Independence Day, Labor Day, Thanksgiving Day, and Christmas Day.

Recent Publications

The following are brief summaries of publications regarding program policy changes since December 1, 2002. For details and further instructions, download the complete notice from the Provider Information website (www.dphhs.state.mt.us/hpsd/medicaid/medpi/medpi.htm). Select *Notices and Replacement Pages*, and then select your provider type for a list of current notices. If you cannot access this information, contact provider relations.

Notices

02/04/03 Outpatient Hospitals, FQHC, RHC, IHS

- UB-92 claims submitted on or after April 1, 2003, will require all line items to have a valid date of services (UB field 45). New
- List of revenue codes that require a separate line for each date of service

01/29/03 Pharmacy Notice

- Termination of coverage for selected drugs
- Change in dispensing limitations New
- Prescription refill change
- Prior authorization changes

01/27/03 Optometric Notice

- Optometric Program Changes. New

01/15/03 Dental Services Program Changes

- Effective February 1, 2003, only emergency dental services are available for clients age 21 and over.
- An *Emergency Dental Services For*m is required for these services. This form is available in the *Forms* section of the website.

01/10/03 All Provider Notice

- Provider notification procedures changes
- Medicaid changes
- PASSPORT ID number changes

01/10/03 Therapy Services Program Changes

- Therapy services limits

01/02/03 Pharmacy Program Changes

- Prior authorization changes

01/02/03 Mental Health Services Providers

- Mental Health Program Changes. Includes a letter to send to clients.

01/01/03 Private Duty Nursing Providers PASSPORT approval required

- Effective February 1, 2003, Private Duty Nursing services require PASSPORT provider approval.

12/01/02 Physician Related Services

- Effective 01/01/03, all subsequent surgical procedures, except codes that are modifier 51 exempt or are add-on codes, will be reimbursed at 50% of the Medicaid allowed amount.
- Mid-level practitioners must bill for services using their own Medicaid ID number.
- A list of several DME codes that are active for physicians, mid-level practitioners and podiatrists.
- A reminder of the vaccines that are covered under the Vaccines for Children Program (VFC). The codes and descriptions are also included.
- Changes in prior authorization procedures.

Manuals

01/06/03 Ambulance Services Manual

- This new manual contains the latest program changes and updates. New

01/02/03 Prescription Drug Prior Authorization Manual

- The new manual updated with prior authorization changes and brand generics information is available on the Provider Information website. New

Manual Replacement Pages

01/02/03 Pharmacy Manual Replacement Pages

- Replacement pages for the Prior Authorization chapter of the Pharmacy manual New

01/02/03 Physician Manual Replacement Pages

- Prior authorization changes New

Montana Medicaid
ACS
P.O. Box 8000
Helena, MT 59604

PRSRT STD
U.S. Postage
PAID
Helena, MT
Permit No. 154

Provider Relations
P.O. Box 4936
Helena, MT 59604

Claims Processing
P.O. Box 8000
Helena, MT 59604

Third Party Liability (TPL)
P.O. Box 5838
Helena, MT 59604

Key Contacts

Provider Information Website:
http://www.dphhs.state.mt.us/hpsd/medicaid/medpi/medpi.htm

Provider Relations (800) 624-3958 Montana
(406) 442-1837 Helena and out-of-state
(406) 442-4402 fax

TPL (800) 624-3958 Montana
(406) 443-1365 Helena and out-of-state

Direct Deposit Deposit Arrangements (406) 444-5283

Verify Client Eligibility:
FAXBACK (800) 714-0075
Automated Voice Response (800) 714-0060

Point-of-sale Help Desk for Pharmacy Claims (800) 365-4944

PASSPORT (800) 480-6823

Prior Authorization:
DMEOPS(406) 444-0190
Mountain-Pacific Quality Healthcare Foundation (800) 262-1545
First Health (800) 770-3084
Transportation (800) 292-7114
Prescriptions (800) 395-7951